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DATE NOTICE SENT TO ALL PARTIES: 1/18/16

IRO CASE #:

DESCRIPTION OF THE SERVICE OR SERVICES IN DISPUTE

The item in dispute is the prospective medical necessity of a right L5/S1 microdiscectomy.

A DESCRIPTION OF THE QUALIFICATIONS FOR EACH PHYSICIAN OR OTHER HEALTH CARE PROVIDER WHO REVIEWED THE DECISION

The reviewer is a Medical Doctor who is board certified in Orthopedic Surgery. The reviewer has been practicing for greater than 10 years.

REVIEW OUTCOME

Upon independent review the reviewer finds that the previous adverse determination/adverse determinations should be:

- ☐ Upheld (Agree)
- ☒ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part/Disagree in part)

The reviewer disagrees with the previous adverse determination regarding the prospective medical necessity of a right L5/S1 microdiscectomy.

A copy of the ODG was not provided by the Carrier or URA for this review.

PATIENT CLINICAL HISTORY [SUMMARY]:

The XX year old has been noted to have persistent low back pain with lower extremity radiation. The injury mechanism was associated with picking up a box of filters. Clinical notes revealed an early diagnosis of a lumbar strain. An EMG/NCV study revealed a possible right-sided L5 radiculopathy. An MRI scan HNP's at L3-4 less than L4-5 less than L5-S1. The radiologist documented that the findings that at L5-S 1 included impingement of the right S1 nerve root (and bilateral L5 nerve roots at the neuroforaminal.). Anterior thecal sac impingement was noted at the more proximal levels. The most recent clinical notes were from XX/XX/XX and XX/XX/XX. On the later date; it was noted that there was persistent low back pain with radiation and "weakness" in the lower extremities. There was a positive right straight leg raise, reduced Achilles reflex along with diminished sensation at right S1. A BMI of 34 was noted. There was

documentation of no apparent psychiatric issues. Treatment trial and failures were noted to have included medications, physical therapy and epidural steroid injections. Denial letters were noted to include it a lack of documented less-on-extension lumbar x-rays and failure of localization of the symptoms to the proposed surgical level, along with lack of documented non-operative comprehensive treatment.

ANALYSIS AND EXPLANATION OF THE DECISION INCLUDE CLINICAL BASIS, FINDINGS AND CONCLUSIONS USED TO SUPPORT THE DECISION.

The combination of the most recent clinical (subjective and objective) findings correlates with the most obviously positive findings on MRI. There have been documented reasonable and comprehensive less invasive treatments tried and failed. With no confounding psychosocial issues, non-operative failures and a positive correlation between the clinical and ancillary tests; guideline criteria as referenced below have been met. The request is medically reasonable and necessary at this time.

Reference: ODG Low Back Chapter, ODG Indications for Surgery-Discectomy/laminectomy –

Required symptoms/findings; imaging studies; & conservative treatments below:

I. Symptoms/Findings which confirm presence of radiculopathy. Objective findings on examination need to be present. Straight leg raising test, crossed straight leg raising and reflex exams should correlate with symptoms and imaging.

Findings require ONE of the following:

- A. L3 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral quadriceps weakness/mild atrophy
 - 2. Mild-to-moderate unilateral quadriceps weakness
 - 3. Unilateral hip/thigh/knee pain
- B. L4 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral quadriceps/anterior tibialis weakness/mild atrophy
 - 2. Mild-to-moderate unilateral quadriceps/anterior tibialis weakness
 - 3. Unilateral hip/thigh/knee/medial pain
- C. L5 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral foot/toe/dorsiflexor weakness/mild atrophy
 - 2. Mild-to-moderate foot/toe/dorsiflexor weakness
 - 3. Unilateral hip/lateral thigh/knee pain
- D. S1 nerve root compression, requiring ONE of the following:
 - 1. Severe unilateral foot/toe/plantar flexor/hamstring weakness/atrophy
 - 2. Moderate unilateral foot/toe/plantar flexor/hamstring weakness
 - 3. Unilateral buttock/posterior thigh/calf pain

(EMGs are optional to obtain unequivocal evidence of radiculopathy but not necessary if radiculopathy is already clinically obvious.)

II. Imaging Studies, requiring ONE of the following, for concordance between radicular findings on radiologic evaluation and physical exam findings:

- A. Nerve root compression (L3, L4, L5, or S1)

- B. Lateral disc rupture
- C. Lateral recess stenosis

Diagnostic imaging modalities, requiring ONE of the following:

- 1. MR imaging
- 2. CT scanning
- 3. Myelography
- 4. CT myelography & X-Ray

III. Conservative Treatments, requiring ALL of the following:

A. Activity modification (not bed rest) after patient education (≥ 2 months)

B. Drug therapy, requiring at least ONE of the following:

- 1. NSAID drug therapy
- 2. Other analgesic therapy
- 3. Muscle relaxants
- 4. Epidural Steroid Injection (ESI)

C. Support provider referral, requiring at least ONE of the following (in order of priority):

- 1. Physical therapy (teach home exercise/stretching)
- 2. Manual therapy (chiropractor or massage therapist)
- 3. Psychological screening that could affect surgical outcome
- 4. Back school

A DESCRIPTION AND THE SOURCE OF THE SCREENING CRITERIA OR OTHER CLINICAL BASIS USED TO MAKE THE DECISION:

- ☐ ACOEM- AMERICAN COLLEGE OF OCCUPATIONAL & ENVIRONMENTAL MEDICINE UM KNOWLEDGEBASE
- ☐ AHCPR- AGENCY FOR HEALTHCARE RESEARCH & QUALITY GUIDELINES
- ☐ DWC- DIVISION OF WORKERS COMPENSATION POLICIES OR GUIDELINES
- ☐ EUROPEAN GUIDELINES FOR MANAGEMENT OF CHRONIC LOW BACK PAIN
- ☐ INTERQUAL CRITERIA
- ☒ MEDICAL JUDGEMENT, CLINICAL EXPERIENCE AND EXPERTISE IN ACCORDANCE WITH ACCEPTED MEDICAL STANDARDS
- ☐ MERCY CENTER CONSENSUS CONFERENCE GUIDELINES
- ☐ MILLIMAN CARE GUIDELINES
- ☒ ODG- OFFICIAL DISABILITY GUIDELINES & TREATMENT GUIDELINES
- ☐ PRESSLEY REED, THE MEDICAL DISABILITY ADVISOR
- ☐ TEXAS GUIDELINES FOR CHIROPRACTIC QUALITY ASSURANCE & PRACTICE PARAMETERS
- ☐ TEXAS TACADA GUIDELINES
- ☐ TMF SCREENING CRITERIA MANUAL
- ☐ PEER REVIEWED NATIONALLY ACCEPTED MEDICAL LITERATURE (PROVIDE A DESCRIPTION)
- ☐ OTHER EVIDENCE BASED, SCIENTIFICALLY VALID, OUTCOME FOCUSED GUIDELINES (PROVIDE A DESCRIPTION)